DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-378 (2/2005)

LEVEL II Preadmission Screening and Resident Review (PASARR) Assessment for Persons With Mental Illness Applying for Admission or Residing in Medicaid-Certified Nursing Homes

Client's Name: _____

VALIDATION OF A SERIOUS MENTAL ILLNESS:

Does the data about the person meet the criteria for the federal definition of a "serious mental illness?"

☐ Yes (all questions below are answered "yes"). Continue with the screening process.
☐ No (at least one question below was answered "no"). No further Level II screening is needed.

Also, indicate the result of this determination on the first page of the facesheet.

1. ☐ Yes ☐ No Does the person have a major mental disorder meeting the diagnostic requirements in DSM III-R of *(circle the applicable diagnosis)* schizophrenia; mood, paranoid, panic or other severe anxiety disorder; somataform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability. **Note: Dementia, as described in DSM III-R, is not considered a major mental disorder, even though it is a mental disorder that leads to a chronic disability.**
2. ☐ Yes ☐ No Has the person's functioning, as a result of the mental disorder, been limited continuously or intermittently during the past 3 to 6 months in at least one of the following areas of major life activity *(check the applicable areas)*:
   - ☐ Interpersonal functioning, including but not limited to: social isolation, altercations with others, difficulty interacting appropriately and communicating effectively with others;
   - ☐ Concentration, persistence, and pace resulting in problems, such as, difficulty completing common tasks found in a workplace, school, or home setting, difficulty in completing tasks on time, or making frequent errors; and
   - ☐ Adaptation to change.
3. ☐ Yes ☐ No Has the person **needed** during the past two years, as a result of the mental disorder: 1) Psychiatric treatment that is more intensive than outpatient care (e.g., partial or inpatient hospitalization) at least two times during the past two years; 2) Supportive services to maintain functioning in the community or in a residential treatment environment (e.g., group home, nursing facility, etc.); OR 3) Intervention by housing or law enforcement officials?

General Directions: The Level II Screen consists of the following five required assessment sections. The objective of each section is noted. All the assessments may be dictated. The Comprehensive Drug History and the Psychosocial Assessment may be written directly on the screen. Each assessment must be signed and dated (date of the completion of the assessment) by the professional who conducted the assessment.

I. COMPREHENSIVE MEDICAL HISTORY AND PHYSICAL (PRIMARY CARE) EXAM DIRECTIONS: a) The objective is to determine the basic medical conditions which are present and to understand how they contribute to the need for nursing home placement; b) Include medical history, review of body systems, review of neurological system, diagnoses and treatment plan; c) If a physician's assistant or nurse practitioner prepares the history and physical, it must be reviewed and signed by a physician.

A. Components of the history and physical

1. Major medical illnesses

a. Include all the basic diagnoses, problems, and symptoms and whether they are stable. If they are not stable, indicate how often they are present and how they affect the person's daily life and ability to care for him/herself. Also, include any abnormal test results.
b. Past significant history
c. May list past diagnoses for completeness if they occurred in the past, but are not currently under treatment, or would not be expected to become active, and therefore, would not have to be taken into consideration when treating any of the current diagnoses. For example, surgical history of

hernia repair, appendectomy, traumatic amputation, history of Rheumatic fever, pneumonia at age 30, etc.

2. Significant family history

3. Review of all systems

4. Physical exam

   a. Vital signs
   b. Exam

5. Neurologic

   a. Motor
   b. Sensory
   c. Gait
   d. Deep tendon reflexes
   e. Cranial nerves
   f. Abnormal reflexes

6. Treatment plan: For each current diagnosis under treatment, identify current treatment, e.g., medication, tests and any intervention or monitoring by nursing or therapy (physical, occupational, speech, etc.)

7. Physician's signature and date

B. Meeting the medical history and physical exam requirement with existing records.

1. A previous hospital admission history and physical exam may be used if:

   a. It is comprehensive and includes most of the points listed; **and**
   b. It was done within the last three (3) months; **and**
   c. It was accompanied by an update which was done within the last ten (10) days; **and**
   d. It is accompanied by the previous records or information that are referenced.

2. Additional modifications can be made to the admission history and exam if they are made on the copy, initialed and dated by a physician.

3. Update

   a. It must be done within the last ten (10) days;
   b. It should cover any major episodes or hospitalizations that have occurred since the date of the hospital admission history and exam which is being used to satisfy this requirement; and
   c. It should address the reason the person is being admitted to the nursing home and his/her physical condition at this time.

4. Medical/Surgical consultations

   a. If there is a medical condition, which is the reason for the nursing home placement and a consultant was involved with the care, then include a copy of the consultation and the key progress note.

II. COMPREHENSIVE DRUG HISTORY (CURRENT OR IMMEDIATE PAST MEDICATIONS USE BY THE PERSON) DIRECTIONS: a) The objective of the Drug History Assessment is to determine al current or immediate past medication that could mask or mimic mental illness symptoms; b) Include all medications prescribed during the last month and the use of PRNs and any use of over-the-counter medications; this section may be dictated or the form below may be used; and c) Drug data can be compiled by physicians, nurses or other staff trained to use the forms; however, the Drug Assessment must be completed by a psychiatrist.

A. All medications

Drug Name/Strength	Dosage Instructions/ Frequency	Reason Prescribed	Date Started	Date Ended	Additional Information, If Available: Side Effects; Level of Awareness/Sedation; Orthostatic Blood Pressure and Pulse Rate; Serum Level

Individual Compiling Drug History Information Date

B. Assessment of drug history to be completed by psychiatrist performing the examination in Part IV. Are current medications masking symptoms or mimicking mental illness in this person?

SIGNATURE - Psychiatrist Date

III. PSYCHOSOCIAL EVALUATION DIRECTIONS: a) The object is to determine the individual's ability to engage in activities of daily living and the level of support that would be needed to assist the individual to perform these activities while in the community; b) The psychosocial evaluation requires the compilation of specific client information upon which the assessments in each category are based. The evaluation data should cover a minimum of two (2) years. If the person has been institutionalized the past two years, provide information regarding functioning level prior to institutionalization; c) The following forms are provided to organize the information that can be compiled by staff trained to go through the person's records. The assessment should be completed and signed off by a QMHP and should include information pertinent to how the individual's mental illness has effected his/her functioning level. This section may be dictated or the form below may be used.

A. Living Situation

Assessment

B. Education

Highest Grade Completed	Year	Date of GED	List any post secondary education (place, credits, degrees, dates)
Special Education Classes			

C. Employment

Name of Employer	Position Title	Dates/Duration Held	Salary (Per Week)	Job Type (see key below)

Assessment

WORK EXPERIENCE - This category refers to a time-limited training process using structured work activities to increase understanding of work value and demands as well as to develop work behavior or work skill.

SHELTERED WORK - This category refers to work for subcompetitive wages or salary in a workshop conducted by a nonprofit organization which provides work under special conditions for persons with disabilities.

SUBSIDIZED - This category refers to work where the employer (or employee) receives monetary inducements from another source to hire (be hired) noncompetitive candidates for work.

COMPETITIVE - This category covers work for remuneration in business, industry, government or other organizations that exercise selective hiring practices based upon qualifications of available applicants. Positions are not time-limited and pay a market wage.

VOLUNTEER WORK - This category refers to work activity where time/service is contributed to an organization that typically accomplishes work by individuals by volunteering.

D. Social History and Supports

1. Marital Status (Note Dates and Changes)

2. Children

Name(s)	Birthdate(s)	Custody Status Including Dates and Reasons for Changes in Custody Status	Additional Information

3. Significant Others (e.g., spouse, parent, landlord, public defender, employer)

Name(s)	Relationship	Additional Information

Assessment

E. Substance Abuse/Illegal Drug Use

Types of Drugs	Amounts	When Use Began and Ended	Additional Information/Treatment History

Assessment

F. Legal Status

Check the Box Indicating Current Legal Status	Dates	Additional Information
Voluntary Admission Involuntary Commitment Protective Placement & Guardian		

Assessment

G. Current Financial Support

Source	Amount	Begin Date	End Date

Assessment

SIGNATURE - Qualified Mental Health Professional (QMHP) Date Completed

IV. FUNCTIONAL ASSESSMENT: a) The objective is to determine the individual's ability to engage in activities of daily living; b) include the level of support which would be needed to assist the individual to perform these activities while living in the community and where that level of support can be provided; c) data for this part of the assessment should be completed and signed off by any member of the team who meets the QMHP requirements.

Note: If the individual is dually diagnosed, completion of the Level II for persons with developmental disabilities meets the requirements for this section.

		What level of support would this person need to assist him/her to perform this activity in the community?	Can this level of support be provided to the individual in an alternative community setting? If so, what setting?	Is this level of support such that NF placement is required?
1.	Self monitoring of health status (including monitoring and supervising one's own health status and self-administering medication and scheduling medical treatment).			
2.	Self-monitoring of nutritional status (eats balanced diet, appropriate snack foods, and fluids).			
3.	Handling money (does not do or has skills but does not have opportunity to do).			
4.	Dressing appropriately (on a daily basis; wears weather related clothing).			
5.	Grooming (personal hygiene, combs hair, brushes teeth).			

SIGNATURE - Qualified Mental Health Professional (QMHP) Date Completed

V. COMPREHENSIVE PSYCHIATRIC AND MENTAL STATUS EVALUATION DIRECTIONS: a) The objective is to determine the individual's psychiatric status and to determine whether or not the individual needs specialized services for those conditions; b) Include treatment history, recent and past psychiatric history, mental status exam, diagnoses and treatment recommendations; c) The data for this part of the assessment can be collected by staff trained to compile the past treatment information, but the assessment must be either reviewed and countersigned or completed by a board certified or board eligible psychiatrist.

A. Psychiatric and Mental Status Assessment

1. Psychiatric Treatment History

Inpatient/Outpatient Treatment History (start with most recent)	Name of Treatment Provider	Dates	Treatment Received	Treatment Outcome

2. Recent Psychiatric History

3. Past Psychiatric History

4. Mental Status Exam

   a. General appearance
   b. Psychomotor
   c. Thought content: current abilities, overt behavior, suicidal/homicidal ideation, reality testing, presence and content of delusions and hallucinations
   d. Thought form
   e. Perceptions
   f. Emotional state - Affect and mood
   g. Orientation
   h. Cognitive functioning and intellect
   i. Judgement
   j. Insight to his/her mental illness

5. Summary of findings, including review of current treatment plan

6. Diagnosis using DSM III-R (all five axes)

7. Specialized services recommendations for each psychiatric diagnosis (include medication and other biological treatments, psychosocial and rehabilitation services, and other symptom management or psychotherapy)

SIGNATURE - Psychiatrist _____ Date Completed _____

B. Meeting the psychiatric/mental status requirement with existing records

1. A previous hospital admission history and psychiatric assessment may be used if:

   a. It is comprehensive and includes most of the points listed; **and**
   b. It was done within the last three (3) months; **and**
   c. It is accompanied by an update that was done within the last ten (10) days; **and**
   d. It is accompanied by the previous records or information that are referenced.

2. Additions and modifications may be made to the admission history and psychiatric assessment if they are made on the copy, initialed and dated.

3. Update

   a. It must be done within the last ten (10) days; **and**
   b. It should cover any mental illness or hospitalization that has occurred since the date of the hospital admission history and physical exam which is being used to satisfy this requirement.